

men. I think the interest of the patient alone should guide in such matters. The consultant whom we summon to our patient may not be the consultant whom we should select for ourselves or families, but there may be many reasons in the interests of our patients to influence us, and the interests of our patients should, I think, be our sole guide. A class of practitioners which I cannot understand includes the men who while engaged in general practice pose as specialists and the consultants who engage in general practice. In this neighbourhood I fear it is not uncommon for a consultant to visit a patient alone. He does so in the first instance for a smaller fee than he would receive in consultation and sometimes pays a second visit without fee—a “friendly” visit he calls it. In this way he enters very closely into competition with the general practitioner. Would it not be better for the practitioner of either kind to restrict himself solely to his proper work? The medical sphere is such a large one that it requires a man’s entire energy to discharge properly his duty in the branch which he has selected for his own work.

“One science only can one genius fit—  
So deep is human knowledge, so shallow human wit.”

#### THE GENERAL PRACTITIONER’S DUTY TO HIMSELF.

If a general practitioner takes pains to make himself efficient, and if he lets the patient benefit by his efficiency, he is certainly entitled to look to the patient for adequate remuneration, and yet how often is he doomed to disappointment? The lines quoted in his presidential address by Dr. Alderson are too often true:—

“God and the doctor we alike adore  
When sickness comes, but not before;  
The danger over, both are alike requited,  
God is forgotten and the doctor slighted.”

To secure prompt remuneration I think it would be better if we could follow the example of barristers, of consultants, and of medical men in Ireland and in some places abroad—that is, to secure our fee at the time of our attendance. “The sick man,” someone has said, “pays willingly while his tears are wet.” Our custom of keeping books and rendering accounts, while it savours of the custom of tradesmen, is often, I think, the cause of serious loss to our pockets.

In the care of his health I fear the general practitioner is too heavily handicapped by the nature of his work to take much heed. For instance, no conscientious practitioner can take an hour for a meal and rest in the middle of the day if the patient who sent early in the morning has not yet been seen. The lunch is postponed. The digestive organs, ready with their juices to receive and digest the expected meal, think their agency is not required and resume a state of inactivity from which they are rudely awakened one, two, or three hours afterwards. They are then called upon for extra work, get worn out early, and dyspepsia results. I think it better to take at the usual meal hour a mere *soupeon* of food, if there is not time for a proper meal, and then wait for the next regular meal hour for a fuller supply. The disturbed sleep, the exposure to weather, the anxiety caused by difficult cases are all matters over which I fear a medical man has little control. No wonder the average years of his life are as low as fifty-seven. He must accept the pains as well as the pleasures of his profession and can only look forward to retirement to be freed from the former and to dwell with gratification upon the latter.

In the matter of recreation I think that no medical man should be without his hobby. It has been said that a man who sticks sufficiently closely to his work finds in it his recreation as well as his means of living. The nature of the practitioner’s work, however, demands that his mind shall be abstracted at times from things morbid. The neglect of this demand is liable to be productive of misery when the time comes for cessation of active work. A celebrated physician complained to his friend in these terms: “I am told I must retire and make way for younger men. I have done nothing all my life but physic people and now I am told to go into the country and grow cabbages.” I grieve to know that this distinguished man’s period of retirement is not as happy as it should be. Lord Bolingbroke, the celebrated statesman of Queen Anne’s reign, said, “Blessed is the man who has a hobby”; and a well-known medical man has said, “If you cannot find pleasure in the study of geology, of natural history, or of astronomy, then by all means make a collection of old walking-sticks, postage stamps, or pieces of cracked china.”

Finally, I would advise a *spirit of contentment* as conducive to happiness in a general practitioner’s lot. His work is surely a creditable one. The necessity of being able to deal

efficiently with disease in all its forms at all times, the ability to treat successfully persons of all ranks and of all tempers, surely compel the possession and the exercise of knowledge and tact which are not surpassed in energy and self-denial by the requirements of any other branch of practice. It is a pity for the medical practitioner having put his hand to the plough to look back or to look above. I am sure many of our consulting brethren could tell us bitter tales of the struggle of their earlier years. In general practice there is much, if we only look for it, to interest and instruct us; much to keep our sympathies green and our spirits contented. Mr. Fildes’s picture, the picture which attracted so much attention a year or two ago, did not pourtray the court physician, whose name is in the paper every day, nor the popular specialist who is the idol of society. The picture represented the general practitioner in the humble cottage, watching the sleeping child and thinking what he will have to tell the parent, and watched himself by the anxious parent trying to forecast what he will have to hear from the doctor. The picture recalls the lines written upon a portrait of the late Mr. Merriman of Kensington:—

“What does it tell us? That to thee  
The noblest task on earth was given,  
The brightest service that we see  
Conferred on mortal under Heaven.  
To heal the sick, to lighten pain,  
To gently cool the heated brow,  
And, like an angel, bring again  
Hope to the hopeless, such wert thou.”

I have referred to the ingratitude of patients, but how often do we receive from them touching evidence of their esteem and affection? How many of us can display valued, if not always valuable, gifts? It is said that a medical man should have his coat made with two pockets—one for his fees, the other for his insults. But is not a third pocket sometimes necessary—one to receive these welcome gifts?

There must surely be something in medical practice to awaken the emotions and stimulate the intellect, for we find the highest forms of literature enriched by the contributions of members of the medical profession—witness the works of Goethe, Sir Thomas Browne, Goldsmith, Smollett, Sir Samuel Garth, Sir Richard Blackmore, Akenside in the past, and besides others Oliver Wendell Holmes, Conan Doyle, and John Watson in the present day. How many of us could write, founded upon our cases, histories like the “Diary of a late Physician” by Samuel Warren, who was a medical man as well as a lawyer? At Monte Carlo one of the English surgeons there informed me that his patients suffered not so much from physical ailments as from nervous tension and exhaustion the result of gambling, and that they went home not with health improved by the climate of the Mediterranean, but with constitutions shattered by excitement.

The family doctor is, perhaps, more than either the clergyman or the lawyer the family friend. He is seen more frequently than either of the others and is consulted about many matters which are not medical. He is looked up to with childlike faith for advice which it is known will be given with neither satire nor contempt. It is his duty to minister to the wounded spirit as well as to the weakened body. In my own case I have been encouraged to do this by the motto of my alma mater, the London Hospital—*Nihil humani alienum puto*.

## A CASE OF CHRONIC INFANTILE MENINGITIS WITH BASAL DRAINAGE.

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AND

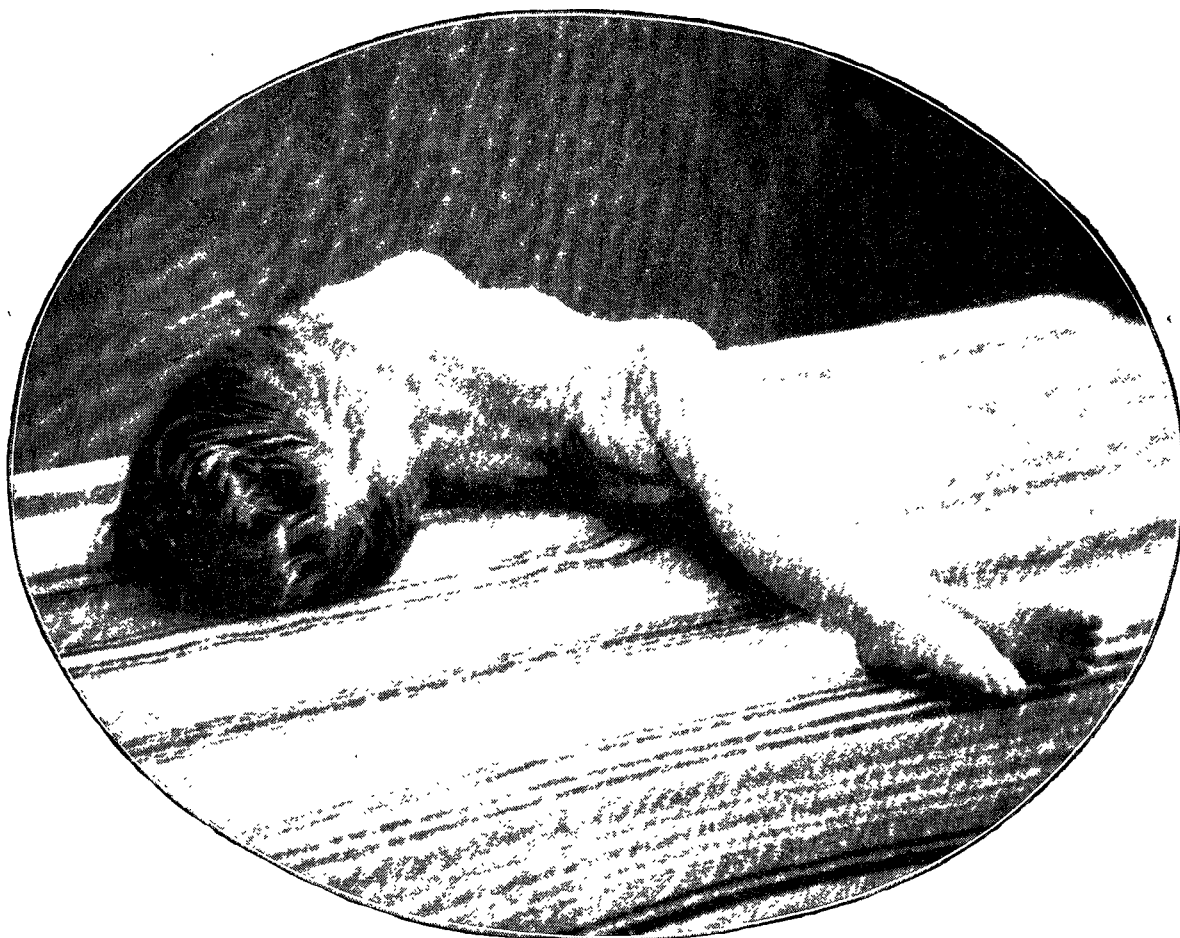
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THE following case is of interest because of the extreme degree of rigidity which gradually became established and also because of an attempt which was made to drain the lateral ventricles through the subcerebellar space. Parkin<sup>1</sup> was the first to perform this operation and gave it the name of “basal” drainage to distinguish it from “cortical” (that is, drainage through the fontanelles and direct puncture

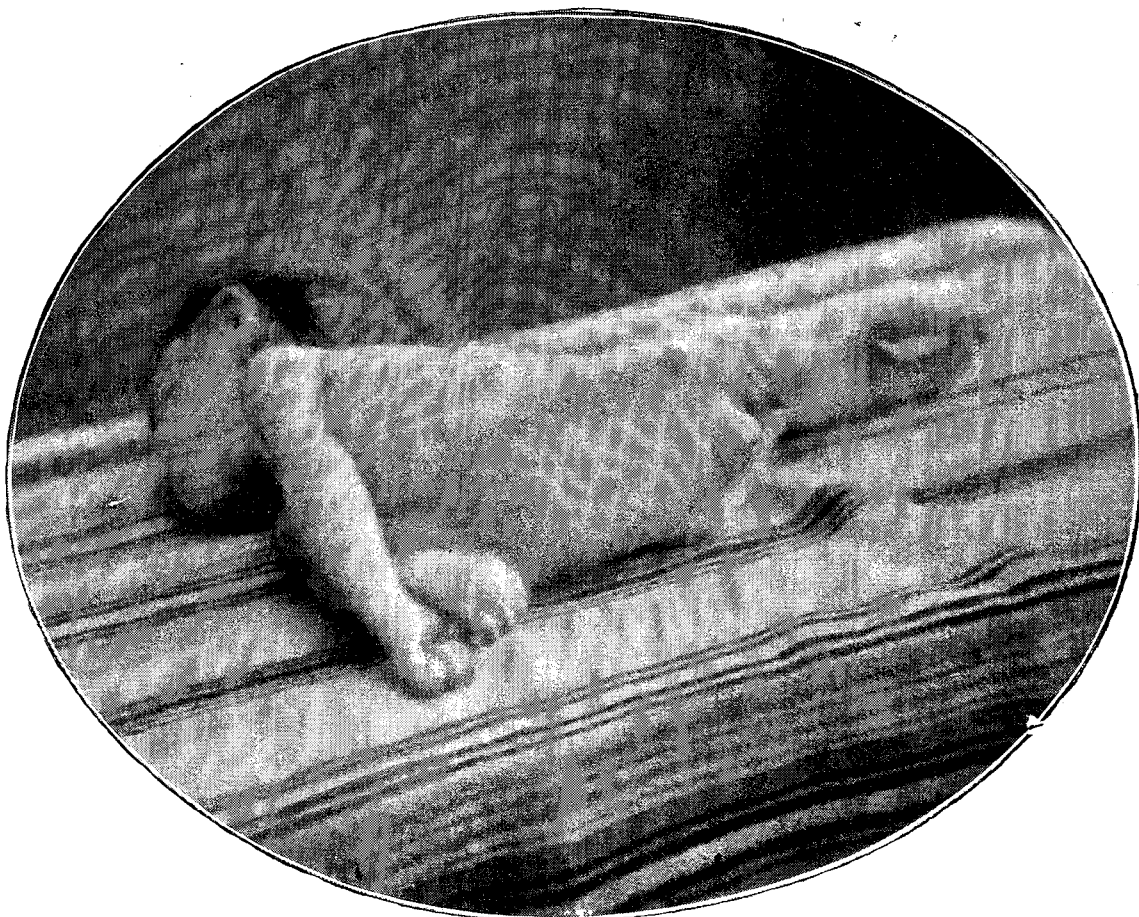
<sup>1</sup> THE LANCET, July 1st and Nov. 18th, 1893.

FIG. 1.



Reproduced from a photograph of the child taken from the back on April 22nd, 1898. The retraction of the head is well marked, but the opisthotonos and rigidity of the legs were more excessive than are apparent from the illustration.

FIG. 2.



Reproduced from a photograph of the child from the ventral aspect taken on the same date, showing pronation of the forearm, extension of the legs, and drawing inwards of the great toes



of the lateral ventricles) and "vertebral" drainage. Subsequently Waterhouse<sup>2</sup> drained the same space in a case of tuberculous meningitis. Glynn and Thomas<sup>3</sup> in 1895 described a case of chronic hydrocephalus in a young man subject to severe headaches, insomnia, and sickness in which the skull was trephined in the occipital area and drainage established, the result being perfectly satisfactory.

The patient, a female child aged ten months, was admitted into Tottenham Hospital on Feb. 16th, 1898. About three weeks previously she fell on her head out of a chair and was sick on the next day with convulsions. She afterwards gradually fell into a drowsy insensible state. Two days before admission she had several screaming attacks and at the same time retraction of the head was noted, but no strabismus. On admission she appeared to be semi-comatose and took no notice. The head was not retracted. The pupils were equal and reacted well to light. There was neither strabismus nor nystagmus. The heart and lungs were normal. There was no tenderness or retraction of the abdomen. The temperature was 97° F. The fontanelles were widely open. During the day the child vomited once. On the 17th the temperature rose to 101°. On the 23rd a vesicular eruption appeared on the face, trunk, and limbs, variceloid in character. This afterwards became purulent and left scars. On March 5th the vomiting had continued and had gradually become worse. Nasal feeding was now commenced and continued throughout the illness. On the 8th a mixture of peptonised milk and chicken broth was given as food and 1 gr. of hydrargyrum cum cretâ every night. As a result the vomiting ceased. On the 11th a purulent discharge commenced from both ears and the temperature again rose to 101°. On the 14th a convulsive attack occurred lasting thirty minutes and the temperature rose to 102°. As the convulsion was not relieved by a hot bath a few whiffs of chloroform were inhaled. The convulsion was general, with arching of the back and retraction of the head. An enema of bromide of potassium (5 grains) and chloral hydrate (1½ grains) was ordered. A lotion of perchloride of mercury (1 in 3000) had been used for syringing the ears. Sherry whey was added to the chicken broth on the 11th and mercurial ointment had been daily rubbed into the abdomen and spine. On the 14th the vomiting also returned and the food was altered to peptonised milk and chicken broth. On the 19th the temperature reached 104° and the breathing was of the Cheyne-Stokes type. The optic discs were somewhat blurred, the veins were full and tortuous, but there was no marked retinitis. On the 26th there had been no more convulsions. The temperature chart was irregular and oscillating. There were now well-marked opisthotonos, retraction of the head, and carpo-pedal contraction. On April 27th the condition was unaltered as regards the rigidity, but the head now began to increase in size. Its circumference measured 19 in., the forehead was prominent, and the sutures were widely separated. Rigidity was extreme. The fingers were clenched, with the thumbs turned inwards, the forearms were prone, and the arms were extended. The legs were extended to such a degree that the feet touched the pillow and were on the same level as the retracted head. The tibiae were rotated outwards and the knee-joints were rigid. The feet were extended and rotated inwards. The great toes were drawn inwards towards the sole. Nystagmus was present to a slight degree and strabismus occurred at times. On May 1st, the head having been prepared for operation in the usual way, Mr. Carson made an incision under chloroform from the external occipital protuberance towards the right mastoid process and turned down a flap of skin. The periosteum was stripped off and a portion of bone between the curved lines about half an inch in diameter was removed. The dura mater was exposed and opened. A bent probe was introduced as far as the tentorium and turned into the fourth ventricle, when about 2½ oz. of clear fluid escaped. A drain made of silk strands was introduced and left inside; the wound in the dura mater was stitched up, skin sutures were inserted, and the wound was dusted and dressed antiseptically. Very little hæmorrhage occurred and the operation proved easy of execution. The child bore the operation well. On the 5th the temperature had now been normal for two days. The child appeared to be somewhat better; there was less retraction of the head and rigidity of the limbs. The arms and legs were massaged daily and the

child retained food well. On the 12th the child steadily became weaker. The stitches were removed on the 7th. The wound had healed and there was still a slight discharge of cerebro-spinal fluid. Death occurred on the 23rd. The illustrations show the posture assumed by the child on the day before death.

At the post-mortem examination great thinning and flattening of the cortex were noticed, with hyperæmia of the pia mater. Over the fourth ventricle and sella turcica the membranes were opaque and thickened. The ventricles were enormously distended with clear fluid and on removing the brain a large quantity of clear fluid escaped from the sides at the base, evidently from the posterior subarachnoid space. The iter and third ventricle were enormously enlarged. The lateral ventricles were so greatly distended that the brain appeared as a mere shell enclosing a reservoir of fluid. The ependyma and septum lucidum were much thickened. The choroid plexuses were relatively insignificant in size. There was no fracture of the bone, no laceration of the brain, and no suppuration within the temporal bones. The purulent discharge from the ears lasted only a few days and was obviously due to dental irritation and not to middle-ear trouble. The spinal cord was healthy and the central canal was of normal dimensions. There was no evidence of syphilis and there were no tubercles.

The causal relation of traumatism to the symptoms appears definite and direct, although the fact that the fontanelles were widely open on admission might lead one to suppose that a chronic hydrocephalus independent of the accident had already commenced. On the other hand, the coma and sickness began immediately after the fall and gradually became more severe during the four months the child survived. It is true that neither fracture nor laceration was discovered at the necropsy, but a laceration might have had time to heal and become obscure. There was certainly much thickening over the sella turcica and in the subcerebellar region. Obviously the result of the injury was to irritate the secreting cells of the ependyma, block efferent lymph channels, increase the circumference of the head and particularly the vertical measurements from ear to ear across the anterior fontanelle.

The operation in itself is not difficult nor is it attended by any special risk. Although the child was in a wretched and impoverished condition she bore the operation well and even improved somewhat afterwards. To be of any use, however, it should be performed as soon as the measurements of the head begin to increase, otherwise the lateral ventricles become dilated beyond any hope of amelioration. Drainage by means of silk strands we found to be unsatisfactory and in future we should be disposed to use capillary rubber tubes provided with an arrangement for preventing the too rapid escape of fluid.

## ON COMBINED PLEURAL AND PERICARDIAL ADHESION.<sup>1</sup>

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MANY years ago I remember to have seen a case which appeared to give much difficulty to my seniors who were in charge of it. I was then scarcely in a position to form an opinion for myself, but I remember that a diagnosis of double pleuritic effusion was made. In the absence in those days of exploring needles this diagnosis was during life neither proved nor disapproved, but after death it was found that both pleuræ were universally adherent, very much thickened even to the thickness of ½ in., and that the pericardium presented a precisely similar condition except that the actual thickness of the fibrous layer was less in the case of the pericardium than the pleura. The case made a great impression upon me, but I have never been led to make much of the bearings of it until one somewhat similar presented itself in the latter half of last year under my own care in Guy's Hospital.

A woman, aged forty-two years, was admitted on May 20th, 1897, for dyspnoea, cough, and pain in the chest. The patient's father and an uncle had died from phthisis; her

<sup>2</sup> THE LANCET, March 10th, 1894.

<sup>3</sup> THE LANCET, Nov. 2nd, 1895.

<sup>1</sup> A paper read before the Nottingham Medico-Chirurgical Society on April 27th, 1898.